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Ethical Decision Making in Resource Allocation Equity in the Military Health Services System

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ETHICAL DECISION MAKING IN THE RESOURCE ALLOCATION PROCESS
Equity in the Military Health Services System

ABSTRACT

The Department of Defense is in the process of restructuring the Military Health Services System (MHSS) and modifying the resource allocation process. This paper examines ethics, primarily the concept of equity, as it relates to the MHSS both before and after the restructuring. Rationing, implicit versus explicit, is discussed. The paper concludes that greater equity in the delivery of care through the MHSS should be achieved through the restructuring process and the implementation of managed health care concepts.

Debra A. Cerha

DISCLAIMER

This research report represents the views of the author and does not necessarily reflect the official opinion of the Industrial College of the Armed Forces, the National Defense University, or the Department of Defense.

FOREWORD

Prior to becoming a student again, I was the Hospital Administrator at a 20-bed Air Force Medical Treatment Facility (MTF). Before I even arrived at the 4th Medical Group, Seymour Johnson AFB, North Carolina, I knew resources would be limited. One day I read an article about how to make ethical decisions when allocating resources--it so impressed me that I wrote the process down on a little, yellow "post-it" note and stuck it on my bulletin board in my new office. It stayed there for the duration of my assignment (2.5 years).

The note is gone now, misplaced during my move, but my concern for the subject remained with me as I entered my tour at the Industrial College of the Armed Forces (ICAF) at Ft Leslie J. McNair, Washington, D.C. When we were offered the opportunity to do a research paper, I decided to revisit this topic. My original intent was to evaluate the military health services system (MHSS) as it operated during my tour at Seymour Johnson. But my best friend is intimately involved with the resource allocation process and was working on the new capitation methodology being devised to support a reorganization of the MHSS into DoD Regions. I decided that it is always better to look forward instead of back...and it might be interesting to see if, in developing a new method of operation for the MHSS, any conscious thought was given to ethics in the resource allocation process. It is also a selfish way for me to keep informed about the system changes during my "sabbatical" at ICAF.

Many individuals assisted me, either through provision of documentation or interviews, during the writing of this paper. I owe a debt of thanks to all of them. Special thanks are in order, however, to Lt Col James Geiger, and to Capt Beth Whitney-Teeple for the tremendous help they provided me before I could even begin this effort. I am forever indebted. . . .

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INTRODUCTION

When ethical dilemmas in health care are discussed, conversations quickly begin revolving around patient-physician centered interactions, e.g., use of experimental drugs, euthanasia, abortion and more recently, genetic engineering. But health care administrators, be they in the policy or operational (hospital/clinic) arenas, have a potentially greater impact, for good or harm, on the ethical functioning of the health care system.[1] Health care ethics include social issues arising from the pursuit of health, such as equal access and methods of financing health care, as well as the actions proper to the patient-physician relationship.

The Department of Defense (DoD) currently is restructuring the Military Health Services System (MHSS) and modifying the resource allocation process. This paper will briefly examine whether any conscious effort was/is being made to imbue an ethical model on the resource allocation process as it was/is being developed. I will then focus on ethical dimensions of health care delivery as a result of this new process.

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[1]Hofreuter, Donald H.(ed.), The Higher Ground, Biomedical Ethics and the Physician Executive, page 15.

RESOURCE ALLOCATION IN THE MHSS

Budgeting and resource allocation *anywhere* in the DoD system is a cumbersome process. Recent changes have further complicated the military medical budget process--and there are more changes coming! Very simply, prior to FY 92, each military medical Service submitted its budget through its respective Service Chief. From there it went through extensive review in DoD, and finally went to Congress for modification/approval. Once funds were authorized, they were given directly to the Service; the Comptroller then distributed funds to each functional area.

In the Air Force for example, medical funds were part of the Air Force budget. If the Medical Service ran short of funds during the year, they appealed to the Comptroller for additional funds. In the Air Force, medical care is viewed as a great morale and retention issue. So, when requests for additional funds were made, they were almost always honored (after much justification and debate between the AF Surgeon General and the Comptroller!).

Funds for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) were handled a bit differently. It was the responsibility of each Service to prepare and justify the budget, and to the limited extent possible, they were to control expenditures. DoD was (and still is) responsible for making payment for processed CHAMPUS claims. DoD would present each Service with a "bill" for these payments. For the Services, this

was a MUST PAY item as this "bill" represented charges from providers for medical services already rendered. With the exception of care requiring a nonavailability statement from a military medical treatment facility (MTF), CHAMPUS claims are submitted by any eligible beneficiaries for services they determine necessary. The Services were liable for payment of bills for services essentially beyond their control. (Many papers have been written on efforts to control CHAMPUS costs; this one will not cover those efforts.)

Since FY 92, the DoD, through the Office of the Assistant Secretary of Defense(Health Affairs) (OASD[HA]), has been responsible for *all* military medical budgets (with the exception of medical war reserve materiel). Initially, not much changed under this new Defense Health Program (DHP)--funds went directly to DoD instead of to the military Service. DoD then distributed the funds to the Services. One major change, though, is that the Services are no longer able to easily supplement the medical budget from the Service budget.

The DHP had a significant impact on operational facilities. This change occurred at a time when the budget was exceptionally lean, medical services at most locations required modification. Let's look at an example....

The first full year of DHP operation, FY 93, found the Air Force

acknowledging a medical shortfall of $160 million. Under the previous approach, during the budget execution year, the Comptroller of the Air Force would help "fix" the medical problem by shifting funds from line accounts into medical accounts. Since this mechanism was no longer available, the Air Force Deputy Chief of Staff advised the MAJCOM Commanders that "the shortfall must be accommodated through management actions."[2] Further, he said:

> you may have to consider such distasteful actions as decreasing/eliminating contracts for dental and emergency room services, decreasing/eliminating laboratory and x-ray support for non-DoD civilian physicians, and curtailing/eliminating the over-the-counter drug programs.[3]

One way might have been to communicate a policy of suspending or eliminating care for beneficiaries with the lowest legal priority (discussed in later section)--but the Services historically found such a position politically unacceptable.

Consequently, at base level, agonizing decisions were made on *how* to limit services. The impact was felt by all categories of beneficiaries but retirees and their dependents were hardest hit. In essence, the decisions made resulted in a form of rationed health care. And the response, by eligible beneficiaries and politicians, was frustrating to those of us trying to balance the budget and the demands. (Example in later section.)

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[2] 8 Jan 93 Message from HQ USAF/CV to all MAJCOM/CCs.

[3] Ibid.

More changes to the MHSS are on their way. In an effort to contain costs and find the most appropriate way to allocate funds from DoD to the operational level, a restructuring scheme is underway. DoD has established 12 defined Regions and is currently in the process of staffing the regional offices. Under this scheme, each regional office will be responsible for distribution and management of the funds allocated for the facilities in their predetermined area.

Consistent with the Clinton Administration Health Care Reform Initiative, funding at the operational level will no longer be workload dependent but rather capitation[4] based. And for the first time (with the exception of a few test programs), individual medical facilities will be accountable for their portion of the CHAMPUS funds; they will be responsible for managing the medical care of all eligible patients.

This DoD plan will structure the MHSS in a manner consistent with a managed care concept. Managed Care is defined by DoD as "a system of health care delivery that influences the utilization of services, costs of services, and measures performance."[5] DoD policy further states that "managed care strategy seeks to

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[4] NOTE: Capitation is generally defined as a prepayment for services, usually on a per member per month basis. This subject is further discussed on pages 18 & 19.

[5] OASD(HA) Memorandum, "Preparing the Military Health Services System (MHSS) for Capitation-based Resource Allocation," with attached Policy Paper, 23 July 1993.

improve resource utilization by changing attitudes where everyone, including the health care providers; pursues, or provides, cost-effective care." And, one might add, some form of rationing will exist, as will be illustrated below.

ETHICAL ISSUES

As previously mentioned, ethical decision making in health care frequently centers on case specific issues--and we all have special stories we remember. I remember the recent case of the Siamese twins born sharing a heart and the subsequent discussions about how only one could live. But even more memorable to me was the fact that the extensive surgery which saved the life of one of the twins cost hundreds of thousands of dollars...and the parents had no health insurance. Who bore the cost of that surgery? Could the resources allocated to save the life of that one child been used to benefit many more? Who/how was it decided which twin should live? These types of decisions, ethical decisions, "should be an integral component of all practice, not just those monumental decisions involving life and death, donors and transplants." [6]

What is ethics? Ethical decision making? Webster's defines ethics as "the body of moral principles or values governing or

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[6] Greipp, Mary Elizabeth, "Greipp's Model of Ethical Decision Making," Journal of Advanced Nursing, 1992, p.734.

distinctive of a particular culture or group" [7] and ethical as "pertaining to or dealing with morals or the principles of morality." [8] So ethical decision making must rely on defined or expressed principles for individuals or agencies/institutions. The basic principles in an ethical framework for individuals or institutions that provide health care include[9]:

Autonomy: the principle supporting self-determination by the client/patient.

Beneficence: the principle directing one toward doing good for the client/patient.

Non-maleficence: the principle guiding one to avoid actions which will harm the client/patient.

Justice: the principle of equity/fairness; respecting the client/patient rights to fair and equitable treatment.

In his article "Ethics in the Management of Health Care Organizations," McCullough discusses the ethical principles of beneficence and autonomy as they relate to how the physician protects and promotes the interest of the patient. Most articles relating to ethics in medicine are patient focused; they deal with either the patient-provider relationship or some new technique or technology that influences individual life and death decisions. It is easy to see why this occurs--all of the principles identified above, generally associated with health

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[7] Webster's Encyclopedic Unabridged Dictionary of the English Language, Gramercy Books, New York, 1989, p.489.

[8] Ibid.

[9] Adapted from the International Council of Nurses' Code for Nurses (1977 and the American Nurses' Association Professional Code for Nursing (1985).

care delivery, focus on the patient. They do not take into account the cost to third parties (individuals or society in general) who may finance the care, or be denied care due to limited resources.

But the times are changing--and maybe it is time for our society (not just philosophers and medical academicians) to look beyond medical ethics in the context of individual patients. In the current social environment, the rising cost of health care and its impact on the national budget, approximately 14% of the Gross Domestic Product, are major news items. Millions of Americans have no health insurance. Unions are striking for improved medical benefits. We are continually bombarded with information on new drugs, medical techniques and technologies that are available. But for whom are they available? And at what cost?

As we begin questioning who makes decisions about individual patients and who pays, the focus moves away from the individual to the family, the community, and taxpayers/society in general. The ethical principle highlighted through discussion of these issues is the one on which I will concentrate--*equity*.

EQUITY IN HEALTH CARE

One must wonder if we will ever be able to achieve a fair and equitable health care system for all Americans.

> The combination of runaway spending and continued problems with access argues for fundamental reform in American healthcare....the necessary reform of American healthcare means confronting the ethical challenges of explicit and systemic healthcare rationing. [10]

Though it is argued by many and others simply will not accept it, rationing does exist today in the American healthcare system.

> It is not rationing by a central authority, but it is rationing nonetheless-rationing by price, and in secondary instances by disease...or by age (as in Medicare) or by race (as in the Indian Health Service) and so on.[11]

Dr. Charles Dougherty, PhD, Director of the Center for Health Policy and Ethics at Creighton University, refers to this form of rationing as implicit, versus the explicit form of rationing used during WWII when coupons for commodities in short supply (e.g., gas and sugar) were distributed. That process assured *some* access to those limited commodities for *all* Americans.[12]

Rationing is typically associated with equity. Dougherty notes that "...rationing means the equitable distribution of a scarce commodity or service."[13] In some regions and for some types of medical coverage, the scarcity of available health care in our

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[10] Dougherty, Charles J., "Ethical Problems in Healthcare Rationing," Health Progress, Oct 91, page 32.

[11] Churchill, Larry R., Rationing Health Care in America: Perceptions and Principles of Justice, University of Notre Dame Press, Notre Dame, IN, 1987, p.14.

[12] Dougherty, Charles J., page 33.

[13] Dougherty, Charles J., "Ethical Problems in Healthcare Rationing," Health Progress, Oct 1991, p.33.

country is likely a result of its poor distribution. The maldistribution of care may be caused by a number of factors, including geographical preferences of providers, location of medical schools, and socioeconomic demographics. Whatever the case, equity in health care *is* a problem. And we cannot afford the cost of unlimited care for all. The debate over national health care is now in progress--can we rely on our politicians to reach a solution? One physician wrote:

> Allocation means value judgements; and votes are lost when politicians have to make value judgements. It involves who gets what treatment and who doesn't. In a country that cannot resolve issues about abortion, gays, gun control, drugs, how will we come to grips with this one?[14]

In addition to redistribution as a mechanism to resolve inequity, another form of rationing may be to restrict care to specified amounts (e.g., a defined benefits package). The politicians do have options. We currently have a multilevel health care system; those with insurance coverage and/or the most resources can afford to get all the care they desire.

> We can formalize this multilevel system so that some can obtain the best care (if they can pay) and make a lower level of care available and/or mandatory for all; or we can have one level of care for all, knowing that level will be significantly less than it is today. Whichever it is, we cannot have the highest level of care available for everyone without an unacceptable increase in cost. This is the single hard choice we face. We can't have it both ways.[15]

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[14] Wilson Art, "Who Will Get the Best Health Care?" Newsweek, 28 Feb 94, page 11.

[15] Wilson, Art, "Who Will Get the Best Health Care?" Newsweek, 28 Feb 94, page 11.

It is not simply politicians that must decide; the American public must face this challenge. The same public that chooses to indulge themselves though overwhelming evidence has been presented about cigarette smoking causing cancer, and the impact of other lifestyle choices (e.g., obesity, lack of exercise) on overall health. Yet, when faced with the associated medical problems, many want society to "pick up the tab" for the medical care that results from these personal choices.

We need to balance individual responsibility for health, societal demand for the best care, and willingness to pay with a finite budget. As noted by one medical ethicist, "...in social policy, the common good must be the value that takes precedence."[16] Would unhealthy lifestyles be modified if they were taxed? I believe they would. Even if modification did not occur, the taxes would contribute to the cost of expected health care needs.

EQUITY IN THE MHSS (prior to regionalization)

What does this discussion have to do with the Military Health Services System? Everyone entitled to military health care receives it, right? WRONG! Though seldom discussed, military health care is subject to rationing in a number of ways:

(1) Legal Limitations
(2) Cost
(3) Access

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[16] Dougherty, p.36.

Legal Limitations

Title X, Chapter 55, of the US Code authorizes medical services for active duty military personnel and entitles their dependents, retired members and their dependents, survivors and other beneficiaries, to military medical care on a space available basis. Those of us who work, or have worked, at the operational level in the MHSS, recognize our responsibility to take care of active duty personnel on a priority basis. When staffing is not available, or when the budget is decreased, those active duty personnel must still be cared for--and that means other eligibles are placed in a queue for services if/when they become available.

As a hospital administrator at a small Air Force MTF, I was acutely aware of the legal authority for care and frequently publicized it so the population understood the basis for many of our resource allocation decisions. Churchill acknowledges that it is always difficult to tell any person they are being denied care because of scarce resources and that there is always a "wish to avoid implications that those who are not treated are less valued as individuals than those who are treated."[17] But that is precisely how many retirees feel when they can not be cared for within a military medical facility.

To augment the military direct health care system, Congress

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[17] Churchill, Larry R., Rationing Healthcare in America: Perceptions and Principles of Justice, page 116.

amended Title X of the US Code in 1966 to establish the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Eligibility for CHAMPUS medical benefits is generally extended to families of active duty service members, retired service members and their spouses and unmarried children, survivors of active or retired members, and certain former spouses. (Active duty and Medicare eligibles are not covered by CHAMPUS).

Though similar in structure to an insurance program, CHAMPUS does not involve a contract guaranteeing indemnification in return for a paid premium.[18] Instead, if and when individuals or families opt to use CHAMPUS, they pay deductibles and cost-shares (based on inpatient vs. outpatient services; number of family members using program; and category of beneficiary, e.g., a retirees cost-share is larger than that of an active duty dependent). The benefits structure for CHAMPUS parallels those of high-option programs available under other public and major private health plans.[19] As new benefits are added to Medicare/Medicaid, they are generally incorporated into the CHAMPUS program as well.

Without spending an excessive amount of time evaluating the CHAMPUS program, it should be evident that rationing occurs based on its legal mandate to cover only specified eligibles. The

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[18] Boyer J. and Sobel, L., Chapter 32. The Managed Health Care Handbook. By Peter R. Kongstevdt, Aspen Publishers Inc., Gaithersburg, MD, 1993, pages 382-383.

[19] Ibid, page 384.

structure of the benefits package often limits usage and thus serves as another method of reducing access to care. Additionally, rationing may also occur by way of physician refusal to accept patients who use CHAMPUS. (This is not as much of a problem since Congress tied CHAMPUS to the Medicare/Medicaid programs. Any physician who accepts patients and government payment for one of these programs must grant patient access for all of them.)

Cost

Military facilities do not charge eligible beneficiaries, with the exception of a very minor daily charge (currently $9.30/day) for inpatient care. Thus direct charges to the patient have little or no negative impact on access. However, the cost associated with various medical supplies or services may result in a management decision to eliminate them from the services the facility offers. For example, a frequent example of cost reductions involves eliminating high cost pharmaceuticals from the formulary (those drugs agreed upon to be stocked by the MTF). Since the facility generally maintains the drugs used to care for active duty personnel, the pharmaceuticals targeted for elimination are most likely ones used by other categories of beneficiaries. This is but one example of reducing access (i.e., rationing) based on cost. There are many others.

Use of the CHAMPUS program may be self-limited by individuals due

to the deductible and cost sharing aspects of the program. Many retirees on fixed incomes, as well as dependents of lower ranking (and thus lower income) personnel, would rather take their chances on gaining access to a military facility (especially in areas with multiple Service MTFs), or go without care at all. The cost burdens of the CHAMPUS program are simply too great for some to accept.

So what happens when the budget is reduced and we try to react responsibly (by living within the budget), ethically (by following the legal limitations as discussed above), and try to educate the population on how to better utilize the resources they do have? I can provide a personal example that, unfortunately, has been replicated by many of my contemporaries. When we had to make the "hard choices" to limit services to certain beneficiaries, primarily retirees and their families, they began a Congressional letter writing campaign (their Congressman just happened to live in the same town as the base where this occurred).

The Congressman was so irate at being bombarded by his constituents, he pestered the Air Force Surgeon General until more funds and personnel were sent to care for his constituents--regardless of the cost. We were in the process of trying to reeducate the population about the finite budget, personal responsibility, etc. His choice was to calm his constituents and

show that he was a worthy voice for them in Congress. This was a set-back as far as the "reeducation process," but even worse, an injustice had been done. Anytime one medical facility receives special/additional resources, it is at the expense of others. Equity within the MHHS was not served....

Access

To accomplish their missions, the Army, Navy and Air Force operate about 1,000 medical and dental treatment facilities worldwide. These facilities vary in size and offer a range of services from limited care at aid stations to a broad range of general and specialty services at large medical centers. Medical Facility size and location is dependent on basing decisions made by the Services and approved by Congress. As such, they are related to the mission, not eligible beneficiaries desiring health care services.

Active duty personnel and their dependents are subject to assignment based upon their mission specialties. Clearly, their eligibility for specialized medical care is a "crapshoot" based on assignments. There are frequent complaints by individuals who must incur large bills under CHAMPUS for care for their dependents vice someone of the same rank/income who was fortunate enough to be assigned where military medical services are available. The Services have implemented humanitarian assignment programs to try to assist individuals who have family members

with chronic/expensive/special medical needs. While these programs are certainly helpful, there continues to be difficulty matching medical needs with mission requirements.

Availability of care due to staffing and facility limitations also results in implicit rationing of services within the military system. Clearly, it is impossible for the Services to justify medical centers with multiple specialties and subspecialties at every base. Consequently, decisions on the medical services offered are based on many factors including the size of the active duty population, availability of health care in the local community, the mission (certain mission requirements drive the need for special medical services, e.g., flight medicine and hyperbaric chambers), and whether it is a suitable location for a graduate medical education program.

These access problems are exactly why the CHAMPUS program was mandated--to offer a cost-effective alternative, and balance the benefits available, to individuals assigned to locations with limited military medical services. CHAMPUS certainly improved the military delivery system that existed prior to that time. Unfortunately, the limitations previously discussed such as cost-sharing and benefits structure, prevent this from being a perfectly equitable program.

EQUITY UNDER THE REGIONALIZATION CONCEPT

Under the regionalization concept, DoD is establishing 12 Regions, each with a lead agent "responsible for maximizing the use of all direct care assets in the region."[20] Key aspects in the design of the MHSS regionalization are:

(1) Funding utilizing capitation budgeting methodology
(2) Structuring the MHSS as a managed care organization
(3) The lead agent management concept

Because the MHSS is subject to many of the same problems as the civilian sector, especially increasing operational costs, it is not difficult to figure out that this restructuring is an effort to make the system more cost-effective and to improve the efficiency of resource use. How will implementation of each of these key aspects affect equity within the MHSS? Was there any conscious consideration of ethical impact in development of these concepts?

Capitation Budgeting

Capitation payment is one of the two basic ways to compensate primary care physicians (PCP). The same amount of money is paid for each member every month regardless of whether or not services are received *and* regardless of how expensive those services are.[21] The goal is to seek efficiency by serving a defined

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[20] 23 July 93 Memorandum to Service Secretaries SUBJECT: Regionalization of the Lead Agency Concept, from ASD(HA).

[21] Kongstevedt, Peter R., The Managed Health Care Handbook, page 55.

population through this financing mechanism. Churchill emphasizes that:

> Neither equality nor efficiency by themselves are worthy goals of a health care system. Both mistake means for ends. The goal of health care is, quite simply, to meet needs. To do so without reference to equality in access or efficiency in outcomes would be unjust.... [22]

The capitation methodology proposed by the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) is not a financing but rather a budgeting mechanism...the philosophy of promoting efficiency, however, is the same. The OASD(HA) capitation formula combines the facility operations and maintenance funds, military personnel salaries and CHAMPUS funding. Dividing this amount by the beneficiary population provides the budgeted amount per person. Concept elements are[23]:

-MTF Commander Accountable for all Resources
-Outcome not Volume
-Discourages Inappropriate Care
-Rewards Efficient Health Care Delivery
-Sensitive to Mission Changes (Population)

Kongstevedt identifies the major problems with capitation as: (1) Chance--the ability to manage the spreading of risk, (2) Perceptions of the physician and staff--a belief that all patients are presenting themselves to receive the care they paid

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[22] Churchill, Larry R., p.130.

[23] Briefing on Defense Health Program Capitation Budgeting, FY 94 by Mr. John Maddy, Acting Assistant Secretary of Defense(Health Budgets and Programs)

for, and (3) Underutilization of services provided to patients.[24] Let's examine these as they relate to equity in the DoD plan.

RISK: In the MHSS, the system prior to capitation promoted implicit rationing. Risk, and higher costs, were avoided by excluding beneficiaries through such things as design of the appointment system, limited service offerings and, as previously mentioned, eliminating drugs known to be used more prevalently by certain categories of beneficiaries. Capitation for the military offers an opportunity to spread and improve management of risk through an explicit rationing mechanism. Capitation will require enrollment so the MTF will know who wants to use the system; for whom it is responsible for care. (Prior to this, beneficiaries could opt in or out of the military system at will.)

Except under limited demonstration or test programs, CHAMPUS dollars were not readily available to the MTF for purchase of services for beneficiaries. Since the local MTF Commanders are now responsible for management of these funds, this system will present an opportunity to utilize these funds and to exercise better control over how they are spent. There is an opportunity to take advantage of economies of scale and to negotiate contracts with a better understanding of who and how much is needed to buy.

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[24] Kongstevedt, The Managed Health Care Handbook, pps 60-61.

This system also affords both the MTF and the patient an opportunity to be better informed about their responsibilities to/for each other. In this system, if rationing occurs through some sort of cost-sharing or stated service limitations, it is an explicit form of rationing. I believe this type of operation will be more acceptable to all parties.

Just as I believe the American public must take more responsibility for their lifestyles, the same is true in the MHSS. Some risk must be returned to the patient, the individual reaping the benefits of expenditure of government funds, if practicing an unhealthy lifestyle. I hope the military will see implementation of capitation/managed care as an opportunity to identify individuals in this category and develop a fair way to assess and "tax" their behavior. A managed care system can support such an objective.

PERCEPTIONS OF PHYSICIANS AND STAFF: In the civilian sector, capitation has resulted in healthcare professionals believing that everyone is coming in for the most expensive care possible at their capitated rate. In the military system, this occurs without capitation.

The perception in the MHSS is that beneficiaries use the miliary healthcare system to get every aspirin they need or for every cold they have. Frequently these individuals express their

belief that they were "promised free medical care and by God, no one is going to cheat them out of it!" The "front line" of our facilities, the physicians, nurses and technicians, hear this *all the time*. Armed with the right information, and coupled with increased emphasis on preventive care and wellness (concepts embodied in managed care), the perception of our beneficiaries and health care professionals should change. There may be a better opportunity for this to occur in the military health care system than the civil system because of our well-defined and more highly educated population.

UNDERUTILIZATION OF SERVICES: The more services used to care for a patient, the higher the cost of the care. In the civilian healthcare sector, it is often alleged that physicians/managed care plans keep their costs down thus improving salaries/profits by underutilizing services. Critics relate the provision of fewer services with the practice of poor quality care.

In the military healthcare system, providers have no control over their income as salaries are set in statute. In fact, those of us who have been responsible for managing the resources of a military MTF are usually concerned with the opposite phenomenon--overutilization of services. In my experience, there are at least three reasons why overutilization has been a problem:

(1) **Workload based budgeting**. Military facilities have received funding based on the amount of "widgets" produced (e.g., admissions, visits, prescriptions dispensed, X-rays exposed). It created the management philosophy of "more is better."

(2) **Lack of profit motive.** Saving money through provision of fewer services has no impact on the salaries of military and government civilians. Since they have no stake in the costs, there is less concern for being conscientious about services provided.

(3) **Malpractice.** Most providers have been trained to provide "defensive medicine" as a result of the litigious society we live in. While there should be less fear of this because the government self-insures providers, their records can still be blemished and their personal legal fees (if they so choose) can be extensive in fighting malpractice suits.

Because there is no direct correlation between utilization of services and providers income in the MHSS, this is not a potential motive for reducing services. Capitation should result in greater analysis and awareness of costs per case to ensure that providers with aberrant practice patterns are not unduly raising the costs of care.

Capitation, combined with the feature of enrollment, should also improve fiscal management because risk will be spread over a large population that will be clearly defined. I am making assumptions here that could be topics for further research--that the funding amount per beneficiary is appropriate and that the population is such that low users of the system will balance out the needs of high users.

If these assumptions are correct, the DoD capitation methodology should provide a more just/equitable system for users. Colonel Paul Kearns, Executive Director, Resources Management in the OASD(HA) stated that no conscious discussion of ethics occurred

in the development of this system; however there is a conscious effort to make the health care benefit more equitable.[25]

The MHSS as a Managed Care Organization

While there are a variety of structural elements involved in development of a managed care organization (e.g., enrollment, case management, utilization review, data analysis, claims processing, defined benefit package), the focus of a managed care operation is efficient utilization of resources. The result should be more cost-effective medical care. In managed care, the aim is to provide the *appropriate* level of care for each patient[26], each diagnosis. Ideally, then, the right amount/type of care is provided--services are never over- or underutilized.

In theory, this system combined with the balance of risk in a capitated system should ensure all patients receive appropriate, cost-effective medical care. Care meeting the needs of each enrolled beneficiary... an equitable benefit **not** an equivalent amount of care. The problem here is how to insure appropriate medical care....

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[25] Personal interview with Col Paul Kearns, 11 Jan 94.

[26] NOTE: When I say "appropriate level of services for the patient," I am referring to the medically indicated needs of the patient based on diagnosis, condition, etc., not necessarily what the patient or family thinks/wants to be done. In addition to issues like who determines the best use of resources (e.g., fertility studies for a 45-year old woman vs. maintaining the life of a 20-week fetus), this leads to a variety of other very different ethical issues which cannot be covered in the scope of this paper.

Because managed care organizations focus on appropriate use of resources, they establish control mechanisms to review, both retrospectively and prospectively, how well they are meeting their objectives. A common tool is a utilization review (UR) mechanism to examine such things as appropriateness of admissions and specialized diagnostic tests, length of stay review, etc.

A managed care organization with a good UR process will have a better chance in meeting its objectives than an organization without one or with an ineffective one. UR must be focused on providing the appropriate level of services for the patient versus underutilizing services to cut costs. The MHSS is attempting to institute UR as part of its managed care concept.

Recently, whether the discussion is healthcare or public education, there is a new focus on outcome/performance standards. A senior official in OASD{HA}(Health Budgets and Programs), Program Review and Evaluation Division, interviewed for this study, emphasized the importance of having some mechanism to evaluate the outcome of care (i.e., how successful was the level of medical intervention [e.g.,surgery, drug therapy] in improving the patient condition). He feels managed care and capitation budgeting can encourage "too little care" or "cutting corners" and that "in the absence of knowing what will work, the wrong things may be eliminated".

Resources have been committed to outcomes research--helping providers figure out what works and what doesn't. The research to-date appears limited primarily to Obstetrical Services. As this information has not yet been disseminated in any sort of policy, operational (MTF level) use of it is essentially nonexistent. I believe we must be realistic enough to accept that attention to outcomes are important when we want to ensure resources are not wasted. But we must also recognize that:

> Pure equality in outcomes, while desirable, is utopian....attention to outcome alone, with expectations of equal health for all, overlooks essential forces at play in health and makes us forgetful of some essentials in health care itself.[27]

It may be difficult to achieve equality (the state of being equal; corresponding in quality, value, etc.) and therefore to achieve equity (the quality of being fair or impartial; just) in outcomes when the inputs to individual health are not always the same. As long as this limitation is recognized, DoD needs to continue research and to deploy of outcome standards to the operational level.

Lead Agent Management Concept

Improved management of DoD medical resources has been a subject of discussion and controversy for many years. It is not my purpose here to enter into an evaluation of all the pros and cons of centralized or tri-Service management of the MHSS; rather, I

[27] Churchill, p.129.

will confine my comments to suggested roles for the Lead Agents.

The Regionalization of the Lead Agent Concept Memorandum from the AASD Health Affairs, 23 July 1993, establishes the responsibility for regional health planning with the respective Lead Agents. Lead Agents are expected to "work closely with the MTF commanders in their region to fully understand the requirements, assets and capabilities within the region as well as maintain consistency with Service policies."[28]

Military beneficiaries who have received care in facilities belonging to the different Services are aware that the Services have differing policies in various aspects of health care delivery (prescription refill policy is a familiar example). To the extent that regional management can examine and change policy conflicts with such policies, it should improve the equity within the system.

But I think that the Lead Agent can play a much broader role in setting an ethical climate within the MHSS. Dougherty reminds us that hard choices about which services are cost-effective and produce the medical outcomes patients seek must be made within the health care arena. He states, "No system can do everything for everybody; healthcare rationing is a call to the value of

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[28] Regional Lead Agent Health Services Planning Guidelines (DRAFT), 7 September, 1993, page 1.

prudent decision making."[29] The Lead Agents can add to the process by acknowledging this fact and being a leader in the "prudent decision making" process.

The concept calls for accountability for resource use to be at the local (MTF) level--and I believe that is where it should be. But those in management/oversight positions must ensure that the patient-provider relationship is not eroded; and they must do this by keeping providers out of individual resource decisions.

> It is important that healthcare rationing decisions be made at the level of social and institutional policy. They should not be clinical decisions made about individual patients at the bedside by their doctors.[30]

Decisions on this basis would not only impact patient trust; they would likely result in inequities in the system. When that happens, patients *and* politicians are dissatisfied with how the MHSS operates.

The Lead Agents are/will be part of the institutional policy setters for resource allocation. They need to step up to that role and ensure local commanders do the same. Feedback between local facilities and the Lead Agencies will be vital to their success. The Lead Agent Management Concept can have a dramatic impact on equity and other aspects of the ethical climate within the MHSS. I hope they embrace the opportunity!

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[29] Dougherty, Charles J., Ethical Problems in Healthcare Rationing, Health Progress, Oct 1991, page 36.

[30] Ibid., page 39.

CONCLUSION

> Philosophical medical ethics over the last decade has largely neglected the macro issues of justice in favor of the micro, individual dilemmas of life and death in intensive care settings.[31]

National Healthcare Reform is forcing the nation to face the "macro issues;" the debates will be long and hard. I fear eventually people will tire and blindly accept whatever the politicians negotiate as fair and equitable. I hope I'm wrong.

But the military health care system has a wonderful opportunity to change without the "media circus" and political debate involved in national health care. This includes the ability to create a more equitable system of care for the 8+ million eligible beneficiaries. Though there was not a conscious effort to improve equity through the current restructuring efforts, implementation appears to support this ethical concept.

It is now time for the health care leaders and managers in the military system to recognize that "...ethical reflection provides the context within which to evaluate and set priorities for the management of health care institutions."[32] Conscious discussion of ethics must occur in resource allocation decision making to further enhance equity in the military health services system.

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[31] Churchill, Larry, page.2.

[32] McCullough, Laurence B., Ethics in the Management of Health Care Organizations, The Physician Executive, Dec 1993.

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